

## NOTICE OF COMPLIANCE REVIEW RIGHTS

**CHILD CARE PROVIDER – SUBJECT TO CONTRACTUAL AUDIT**

Provider’s Name (*Last, First, M.I.*) \_\_\_\_\_ Provider’s I.D. NO. \_\_\_\_\_  
 Location Address (*No., Street*) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
 Phone Number (*Include area code*) \_\_\_\_\_

**ARIZONA DEPARTMENT OF ECONOMIC SECURITY - CHILD CARE ADMINISTRATION CONTRACTS UNIT**

Reviewer \_\_\_\_\_ Accompanied By \_\_\_\_\_  
 Date \_\_\_\_\_ Arrival Time \_\_\_\_\_ Departure Time \_\_\_\_\_

1. The purpose of this review is to evaluate compliance with your Child Care Provider’s Registration Agreement (*Agreement*). The Agreement provides for Contractual reviews pursuant to Section 3.8 (*Record Keeping Requirements*), Section 3.18 (*Contract Compliance Review*), Section 3.19 (*Supporting Documents and Information*), Section 4.5 (*Property of State*), Section 4.6 (*Visitation, Inspection, and Copying*), and Section 8.0 (*Audit*).
2. No fees are charged for this review.
3. An authorized representative of this facility may accompany the reviewer(s) during the compliance review conducted on these premises, except during any confidential interview.
4. You have the right to receive copies of any original documents taken by the reviewer(s) during the compliance review in those cases where the agency has authority to take original documents.
5. Each person interviewed during this review will be informed that statements made by the person may be included in the compliance review report.
6. Each person whose conversations are being tape recorded during the compliance review will be informed that the conversation is being tape recorded.
7. If you have and questions regarding this compliance review, you may contact:

Name \_\_\_\_\_ Title \_\_\_\_\_  
 Address (*No., Street, City, State, ZIP*) \_\_\_\_\_  
 Phone Number (*Include area code*) \_\_\_\_\_

Upon entry onto the premises for this compliance review, the Child Care Administration reviewer(s) identified above presented photo identification indicating that they are Department of Economic Security employees and reviewed with me the above Notice of Compliance Review Rights. I have read the disclosures above and have been notified of my compliance review rights above. I understand that while I have the right to decline to sign this form, The Department of Economic Security representatives may nevertheless proceed with the compliance review.

Child Care Provider refused to sign this form

The regulated person or authorized on-site representative is not present.

Provider Signature: \_\_\_\_\_ Date \_\_\_\_\_  
 Please Print Name and Title \_\_\_\_\_  
 Reviewers Signature \_\_\_\_\_ Date \_\_\_\_\_

**Routing:** Original – Contractor/Reviewer, Copy - Provider

## NOTICE OF COMPLIANCE REVIEW RIGHTS

Provider's Name \_\_\_\_\_ Date \_\_\_\_\_

### Arizona Department of Economic Security ~ Child Care Administration ~ Provider Contracts Unit

#### COMPLIANCE REQUIREMENTS

Sign-In/Sign-Out Record (SISO)    DES (CC-218)    Other \_\_\_\_\_

SISO's pulled:    Yes    No    (see Page 6 - Document Receipt)

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Provider/Parent/Guardian Agreement (CC-208)    Randomly checked (#): \_\_\_\_\_

Best of Care Form    Yes    No    DES (CCA-1200A)    Other

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Expulsion (*children have been expelled or suspended*) ?    Yes    No

Provider Received:    Resource Flyer  
   (CCA -1203A) Request for Child Care Resources  
   (CCA-1204A) Notification of Child Care Expulsion

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Group Size**

AGE GROUP	DHS RATIO REQUIREMENT	MAXIMUM GROUP SIZE	YES	NO
Infants	1:5 or 2:11	11		
1 year old children	1:6 or 2:13	13		
2 year old children	1:8	16		
3 year old children	1:13	26		
4 year old children	1:15	30		
5 year old children; ( <i>not school-age</i> )	1:20	40		
School age children	1:20	40		

Comments: \_\_\_\_\_

\_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date \_\_\_\_\_

### NOTICE OF COMPLIANCE REVIEW RIGHTS

Provider's Name \_\_\_\_\_ Date \_\_\_\_\_

First Things First - Star Rating:    N/A    Waiting List    Pending    1    2    3    4    5

Comments: \_\_\_\_\_

National Accreditation Agency:    Yes    No    Agency: \_\_\_\_\_    Expires: \_\_\_\_\_

Enhanced Rates    SNC    10%    20%

Comments: \_\_\_\_\_

Food Program    Yes    No    Sponsor: \_\_\_\_\_

Comments: \_\_\_\_\_

Commercial Liability Insurance    Yes    No    Agency: \_\_\_\_\_    Expires: \_\_\_\_\_

Comments: \_\_\_\_\_

Email Address (if different from file): \_\_\_\_\_

Comments: \_\_\_\_\_

**Training Mandated:**

CBT Billing / New Provider Orientation / 90-day New Employee / Other (eg:Quorum)

EMPLOYEE FIRST / LAST NAME	EMPLOYEE EMAIL ADDRESS	EMPLOYEE TEL #	TYPE

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional Changes to Report: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date \_\_\_\_\_

## NOTICE OF COMPLIANCE REVIEW RIGHTS

Provider's Name \_\_\_\_\_ Date \_\_\_\_\_

ATTENDANCE VERIFICATION						
CLASSROOM/AGE:		SIGNED- IN TODAY (√)	DES (√)	PRIVATE (√)	SCHOLARSHIPS	
TEACHER(S)					FTF (√)	OTHER (√)
CHILD'S NAME						
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date \_\_\_\_\_

## NOTICE OF COMPLIANCE REVIEW RIGHTS

Provider's Name \_\_\_\_\_ Date \_\_\_\_\_

**AZ Workforce Registry Administrator:** \_\_\_\_\_

	FULL NAME	TITLE	WORKFORCE REGISTRY COMPLIANT	BACKGROUND CHECK COMPLIANT	HERE TODAY	ENROLLED CHILDREN
			Y/N	Y/N	Y/N	Y/N
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

**Additional Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date \_\_\_\_\_

## NOTICE OF COMPLIANCE REVIEW RIGHTS

Provider's Name \_\_\_\_\_ Date \_\_\_\_\_

The Provider Contracts Unit requested and acquired the following records for all children who were in attendance and/or for whom you received payment in the months below.

REQ'D (√)	SERVICE MONTH	YEAR	NOT AVAILABLE (√)	COUNT CONFIRMED			TYPE (√)	
				ACTUAL COUNT	CONTRACTS UNIT (INITIALS)	ACTUAL COUNT	PROVIDER OR DESIGNEE (INITIALS)	WHITE (W) YELLOW (Y) COPY (C)
	January							(W) (Y) (C)
	February							(W) (Y) (C)
	March							(W) (Y) (C)
	April							(W) (Y) (C)
	May							(W) (Y) (C)
	June							(W) (Y) (C)
	July							(W) (Y) (C)
	August							(W) (Y) (C)
	September							(W) (Y) (C)
	October							(W) (Y) (C)
	November							(W) (Y) (C)
	December							(W) (Y) (C)

Sign-In/Sign-Out Records were not immediately available (*please see attached page 6*). Pursuant to Section 3.8.2.C 1-3 (*Record Keeping Requirements*). All DES required records for the current month and for the six (6) most recent months shall be on site and immediately available for viewing. All records older than six (6) months may be stored off site; however, they shall be readily available to the Department.

Provider has only ONE (1) copy available. Originals counted/taken today. DES will mail back copies to Provider within 10 days by: \_\_\_\_\_ (*Date*).

Any records submitted after the site visit may not be accepted and may result in an overpayment. Provider initials: \_\_\_\_\_

Comments: \_\_\_\_\_

Submitted by: \_\_\_\_\_ Date \_\_\_\_\_  
*Provider OR Designee*

Please print name: \_\_\_\_\_  
*Provider OR Designee*

Received by: \_\_\_\_\_ Date \_\_\_\_\_  
*Provider Contracts Unit Representative*

### NOTICE OF COMPLIANCE REVIEW RIGHTS

Provider's Name \_\_\_\_\_ Date \_\_\_\_\_

#### SITE VISIT FOLLOW-UP REGARDING SIGN-IN/SIGN-OUT RECORDS

Please provide the *Sign-In/Sign-Out Record's* that were not available at the time of the site visit no later than close of business: 5:00 PM on \_\_\_\_\_ (Date)

**DROP OFF TO: Child Care Provider Contracts Unit  
1789 W. Jefferson St.  
Phoenix, AZ 85007**

**DROP OFF TO:** \_\_\_\_\_  
(alternate address)

**MAIL TO: Post Office Box 6123, M/D5474, Phoenix, AZ 85005**

**SPECIAL NOTE: Records must be date and time stamped by the Department of Economic Security, Child Care Administration to be considered.**

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Please print name: \_\_\_\_\_

#### DOCUMENT RECEIPT

The Department requested and acquired the following records for all children who were in attendance and/or for whom you received payment for the months below.

SERVICE MONTH/YEAR	ACTUAL COUNT	CONTRACT UNIT INITIALS	PROVIDER OR DESIGNEE INITIALS	COPY YELLOW WHITE

Submitted by: \_\_\_\_\_ Date \_\_\_\_\_  
*Provider OR Designee*

Please print name: \_\_\_\_\_  
*Provider OR Designee*

Received by: \_\_\_\_\_ Date \_\_\_\_\_  
*Provider Contracts Unit Representative*

## NOTICE OF COMPLIANCE REVIEW RIGHTS

Provider's Name \_\_\_\_\_ Date \_\_\_\_\_

**SITE VISIT NOTIFICATION**

This is a notification from the Arizona Department of Economic Security (ADES), Child Care Administration (CCA). On \_\_\_\_\_ (date), \_\_\_\_\_ (time), CCA attempted to conduct a site visit at your facility during the business hours indicated on your contract. The visit was unsuccessful due to your absence. Per the section of the ADES Registration Agreement quoted below you or your staff is required to be present during regular business hours.

**4.6 Visitation, Inspection and Copying**

*For the purposes of Section 8.0, Audit, of this Agreement and for any other reason the Department deems necessary, your facilities, services, books, and records pertaining to the Agreement shall be available for visitation, inspection and copying by the Department and any other appropriate agent of the state or federal governments. At the discretion of the Department, visitation, inspection and copying may be at any time during regular business hours, announced or unannounced. If the Department deems it to be an emergency situation, it may at any time visit and inspect your facilities and services, as well as inspect and copy Agreement related books and records.*

Provider Name: \_\_\_\_\_

Provider ID: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

**CONTRACTED DAYS & HOURS OF OPERATION:**

Days:    M    T    W    T    F    S    S    24 Hours    Hours: \_\_\_\_\_ : \_\_\_\_\_    AM    PM

ATTEMPTED VISIT(S)	
#1 Date: _____ Time: _____ : _____    AM    PM	#2 Date: _____ Time: _____ : _____    AM    PM
ATTEMPTED PHONE CALL(S) – SAME DAY AS VISIT (USED PHONE NUMBERS ABOVE)	
#1 Time: _____ : _____    AM    PM	#2 Time: _____ : _____    AM    PM

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please contact your assigned Provider Contracts Administrator:

\_\_\_\_\_ at \_\_\_\_\_  
*Provider Contracts Administrator Name* *Phone Number*

Provider Contracts Administrator Signature \_\_\_\_\_ Date \_\_\_\_\_

**Original:** Provider  
**Copy:** Provider's file

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact 602-542-4248; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request.